1997-98 SESSION COMMITTEE HEARING RECORDS

Committee Name:

Joint Committee on Finance (JC-Fi)

Sample:

Record of Comm. Proceedings … RCP
- 05hrAC-EdR_RCP_pt01a
- 05hrAC-EdR_RCP_pt01b
- 05hrAC-EdR_RCP_pt02

- *Appointments … Appt*
- **

- *Clearinghouse Rules … CRule*
- **

- *Committee Hearings … CH*
- **

- *Committee Reports … CR*
- **

- *Executive Sessions … ES*
- **

- *Hearing Records … HR*
- **

- *Miscellaneous … Misc*
- *97hrJC-Fi_Misc_pt65b_LFB*

- *Record of Comm. Proceedings … RCP*
- **

To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Nursing Homes -- Delicensing Beds and the Minimum Occupancy Standard (DHFS -- Medical Assistance)

[LFB Summary: Page 262, #6]

CURRENT LAW

Prior to 1995 Wisconsin Act 27, the medical assistance (MA) nursing home formula applied a minimum occupancy standard to the daily payment rate for only four of six cost centers (administration, fuel and utilities, property tax and capital costs). When determining the payment per patient day for these four cost centers for the current year, the total allowable costs from the base cost reporting period (an earlier period) were divided by either: (a) the actual adjusted patient days; or (b) patient days based on 91% of occupancy for that earlier period, whichever is higher. If a nursing home had an occupancy rate less than 91%, the allowed rate per patient day would be inadequate to recover all of the homes's costs and the formula would penalize nursing homes that did not fully utilize their facilities.

Provisions of Act 27 extended the minimum occupancy standard to the remaining two cost centers, direct care and support services, beginning in the 1995-96 fiscal year. These two cost centers represent approximately 75% of nursing home costs.

Under rules effective prior to 1995-96, a nursing home substantially below the 91% occupancy could avoid the effect of the minimum occupancy standard by relinquishing the use of either 25% of its licensed beds or 50 licensed beds. If a facility relinquished this number of licensed beds, its rate could be reestablished. However, future use of the relinquished beds would not be available to the facility.

When the Department of Health and Family Service (DHFS) established the rules for nursing home reimbursement for 1995-96 and 1996-97, DHFS included several "windows" that allowed nursing homes additional ways to reduce the number of licensed beds without meeting the threshold requirement of either 25% of licensed beds or 50 beds.

GOVERNOR

Authorize DHFS to approve a request by a nursing home to delicense any of the nursing home's licensed beds if the bed occupancy of the nursing home is below the minimum patient occupancy standard (currently 91%) so that the nursing home can avoid the effect of the minimum occupancy standard on its MA reimbursement. Specify that if DHFS approves the request, all of the following would apply:

a. DHFS would be required to delicense the number of beds in accordance with the nursing home's request;

b. DHFS would be prohibited from including the delicensed beds in the number of beds of the nursing home in determining the costs per patient day under the minimum occupancy standard;

c. The nursing home would be prohibited from selling a bed that is delicensed;

d. Every 12 months following the delicensure of a bed for which a nursing home has not resumed licensure, DHFS would be required to reduce the licensed bed capacity of the nursing home by 10% of all the nursing home's beds that remain delicensed, or by 25% of one bed, whichever is greater; and

e. The nursing home could resume licensure of delicensed beds, unless the licensed bed capacity of the nursing home bed was reduced as provided under (d), 18 months after it notified DHFS in writing that it intended to resume licensure. Nursing homes would be prohibited from resuming licensure of a fraction of a bed. If a nursing home resumed licensure of a bed, DHFS would include those beds in the application of the minimum occupancy standard for purposes of the MA reimbursement rate calculation.

DISCUSSION POINTS

1. When 1995 Act 27 was passed, it was anticipated that the extension of the 91% minimum occupancy standard to direct care and support costs would reduce MA nursing home expenditures by approximately $15.0 million (all funds) annually. Although it is not possible to determine to what extent these cost savings were realized, it is estimated that the windows

established by DHFS as a means of enabling nursing homes to avoid financial penalties resulting from the 91% occupancy standard resulted in a reduction of savings (all funds) of approximately $11.0 million in 1995-96 and $12.2 million in 1996-97.

2. DHFS offered nursing homes the following windows in 1995-96 to enable them to reduce their number of licensed beds to meet the 91% minimum occupancy standard.

- Any reduction in licensed bed capacity between June 30, 1995 and November 30, 1995;

- The proposed number of licensed bed reallocations to other facilities under an application under the resource allocation program (RAP) submitted between June 30, 1995, and November 30, 1995 (no adjustment would be made if the application is subsequently withdrawn or denied unless the nursing home reduced its licensed bed capacity by the same amount);

- An adjustment for licensed beds temporarily out-of-use due to renovation projects during the base reporting period;

- An adjustment for isolation beds that were vacant during the base reporting period; and

- Forty percent of the reduction in licensed bed capacity of non-county operated nursing homes during the period between February 14, 1995, and July 1, 1995.

3. For 1996-97, DHFS incorporated the reductions in 1995-96 and allowed the following additional adjustments or windows:

- Any reduction in licensed bed capacity between June 30, 1996, and October 30, 1996; and

- The proposed number of licensed bed reallocations to other facilities under an application under the RAP submitted between June 30, 1995 and November 30, 1995, or between June 30, 1996 and November 30, 1996. For applications submitted during the July 1 through November 30, 1995 time period, the RAP application must be declared complete by November 30, 1996 and approved by March 1, 1997. For applications submitted during the July 1 through November 30, 1996 time period, the RAP application must be declared complete and the project approved within 12 months of submission.

4. A nursing home that is substantially below the minimum occupancy standard that did not take advantage of the windows offered in 1995-96 and 1996-97 can avoid the effect of the 91% minimum occupancy standard by relinquishing the use of either 25% of its licensed beds

or 50 licensed beds. If a facility relinquishes this number of licensed beds, its rate can be reestablished. However, future use of the relinquished beds will not be available to the facility.

5. The Governor's proposal would allow facilities to delicense beds without any minimum threshold amount, and would only impose a gradual loss (10% per year) of the number of delicensed beds.

6. If every nursing facility took advantage of the Governor's provision for bed banking, it is estimated that MA nursing home expenditures would increase by $4.5 to $6.0 million, annually, if no other adjustments were made to the nursing home formula. However, it is unlikely that every facility would utilize this provision.

7. Since the 91% minimum occupancy standard applies to all cost centers, this requirement can have a substantial effect on a nursing home's reimbursement rate. Based on the most recent final cost reports for 354 of 440 facilities, there were 65 nursing facilities with an occupancy rate below 91%. Of these facilities, the lowest reported occupancy rate was 70.2%, which would result in a reduction to its MA payment of 23% below its allowable costs.

8. Some nursing homes have not taken advantage of the previous windows to reduce nursing home beds since lease agreements, mortgages or other contracts require some facilities to maintain their current licensed beds. These homes also would not be able to take advantage of the Governor's proposal for delicensing beds because of the annual 10% loss of their licensed capacity for any banked beds. Due to this constraint, the nursing home industry is seeking an amendment to the Governor's proposal that would exempt facilities with these legal contracts from the 10% annual loss in licensed capacity.

9. If an exemption to the 10% annual loss is provided to facilities with contracts requiring maintenance of its licensed bed capacity, an additional provision could be added for this group so that beds would not be banked without any potential penalty. If a facility with contracts delicenses any of its beds, and subsequently returns any of those delicensed beds to service, the facility's reimbursement rate could be recalculated for the years in which the beds were delicensed and the difference in payments would be recouped.

10. The fiscal effect of the Governor's proposal for bed banking is difficult to determine for several reasons. First, it is not known how many nursing homes will utilize bed banking. Second, because DHFS has the administrative authority to modify the nursing home formula and attempts to adjust it so as to not expend more than the amounts budgeted for nursing home payments, it is possible that any individual formula change will be offset by administrative changes made by DHFS to maintain nursing home expenditures within budget. However, as demonstrated by the Department's implementation of the 91% occupancy standard in the 1995-97 biennium, administrative changes DHFS makes to the nursing home formula are not always cost neutral.

ALTERNATIVES TO BILL

1. Approve the Governor's recommended statutory changes relating to delicensing of beds and the minimum occupancy standard.

2. Adopt the Governor's recommended statutory changes. In addition, create two provisions applicable to facilities that have entered into contracts prior to January 1, 1996, by: (a) exempting these facilities from the 10% annual reductions to licensed bed capacity for beds that are delicensed for the period of the contract; and (b) specifying that if the delicensed beds are returned to service in the future, the facility's reimbursement rate would be recalculated for the years in which the beds were delicensed and not subject to the 10% reduction and the difference in payments would be recouped.

3. Maintain current law.

Prepared by: Richard Megna

withdrawn

MO# Alt 3

BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

AYE _____ NO _____ ABS _____

MO# Alt 2

BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

AYE 15 NO 1 ABS 0

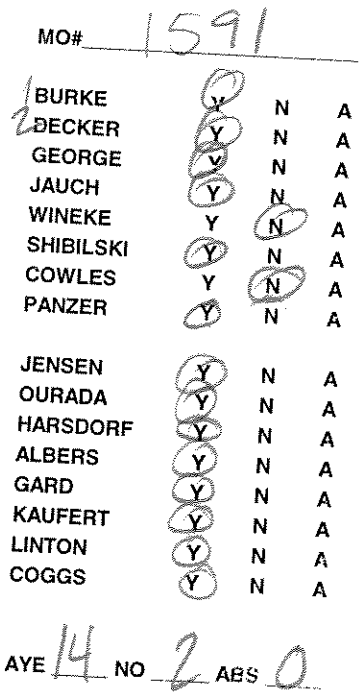
Senator Burke

HEALTH AND FAMILY SERVICES

Use of Three-Year Average for
Minimum Occupancy Standard

Motion:

Move to modify the Governor's recommendations for delicensing nursing home beds and the minimum occupancy standard to require that the Department of Health and Family Services use a three-year average for the occupancy rate in applying the minimum occupancy standard.



Motion #1591

To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Intergovernmental Transfer Program (DHFS -- Medical Assistance)

CURRENT LAW

Under Wisconsin's intergovernmental transfer program (IGT), the state certifies counties' MA allowable expenditures and claims federal matching funds for those expenditures at the regular federal MA matching rate (approximately 59% FED).

Prior to the 1993-95 biennium, use of the IGT was limited to the county federal financial participation (FFP) program, under which DHFS distributed all federal funds generated by county nursing home unreimbursed expenses to county nursing homes. In 1992-93, $15.0 million of federal funding was generated under the FFP program.

Beginning in 1993-94, the amounts of IGT claims increased significantly. In 1993-94, Wisconsin claimed $49.0 million under the IGT, while in 1996-97, DHFS plans to claim a total of $109.7 million under the program. The 1996-97, IGT funds will be used to fund: (a) $37.1 million in special supplemental payments to county-owned nursing homes; and (b) $72.6 million in state GPR costs for MA payments to all nursing homes.

GOVERNOR

Maintain base IGT funding for supplemental payments to counties at the current level of $37.1 million annually. In addition, maintain the provision that any IGT funds in excess of budgeted amounts will be allocated as additional county supplemental payments.

DISCUSSION POINTS

1. The IGT program has grown substantially since 1992-93. Table 1 illustrates the expansion of IGT claims and the distribution of the additional federal MA funds generated under the program. In conjunction with the expansion, the state began using part of the IGT funds for support of general nursing home rate increases and other MA costs.

TABLE 1

Intergovernmental Transfer Program Based on Unreimbursed Expenses of County-Operated Nursing Homes
1992-93 to 1997-99
(In Millions)

Fiscal Year	County Certified Losses	Accrued Federal Matching Funds Available (IGT)	IGT Used As County Supplemental Payments Paid in Current Year	IGT Used as an Offset to State GPR Costs for MA Paid in Current Year	Total IGT Used as a County Supplemental Payment or Offset to State GPR Costs Paid in Current Year
1992-93	$46.3	$70.6	$15.0	$0.0	$15.0
1993-94	43.1	65.9	52.1	5.4	57.5
1994-95	48.1	72.1	55.7	30.4	86.1
1995-96	52.2*	77.3	37.1	26.1	63.2
1996-97 **	59.2	85.7	37.1	72.7	109.8
1997-98	63.6	91.0	41.7	50.4	92.1
1998-99	68.0	96.4	37.1	58.3	95.4

*County losses in 1995-96 totaled $56.4 million, but only $52.2 million was used due to concerns of exceeding the medicare upper limit.

**Since the estimated IGT available in 1996-97 was higher than the budgeted amount of $81.2 million, an additional $4.6 million will likely be paid to counties in 1997-98.

2. An important constraint for claiming IGT funds is the federal limitation that total MA payments, which would include the county match and federal IGT funds, cannot exceed the amount that the state estimates would have been paid under medicare payment principles in effect at the time the services were provided. This payment limitation is referred to as the "medicare upper limit." For both nursing homes and hospitals, Wisconsin is close to the upper limit.

In 1995-96, Wisconsin did not claim all the IGT that was possible due to upper limit concerns. In 1996-97, there is an estimated gap of $21.8 million. Because of the higher rate increases for nursing homes that are designed to catch up for past inflation, it is anticipated that the gap will narrow in 1997-98.

3. In the 1995-97 biennium, the amount of IGT funds allocated for supplemental payments to county-operated facilities totaled $37.1 million annually. In addition, the 1995-97 biennial budget act provided the potential for additional supplemental payments to county-operated facilities if IGT funds were higher than projected in the budget. In the 1995-96 fiscal year, although unreimbursed expenses for county-operated facilities were greater than projected, the Department did not claim more IGT funds because of concerns about violating the medicare upper limit for nursing home payments. It is likely that additional county supplemental payments will be made in 1996-97; based on estimates in SB 77, there is approximately $4.6 million that will be available for counties in 1996-97 under this provision. These payments will be made in the 1997-98 fiscal year.

4. Senate Bill 77 assumes that a total of $91.0 million in 1997-98 and $96.3 million in 1998-99 in IGT funds will be available, based on projected losses by counties. The budget does not modify amounts budgeted for county supplemental payments ($37.1 million annually). The remainder ($50.4 million in 1997-98 and $58.3 million in 1998-99) would be used to offset state MA costs. As was the case for 1995-97, any IGT funding above these budgeted amounts would be reserved for supplemental payments to county-owned nursing homes.

5. Some counties have expressed concerns about the use of IGT funds for general rate increases and have maintained that all or more of the federal funding based on county unreimbursed expenses should be directed solely to county nursing homes.

6. The amount of IGT funds that can be claimed by the state is dependent on two factors: (a) unreimbursed county nursing home expenses; and (b) the medicare upper limit. Federal funds would not be provided based on county unreimbursed expenses if the state's MA nursing home expenditures exceed the medicare upper limit. Unreimbursed expenses of non-county nursing homes allow the state to claim additional IGT dollars based on county unreimbursed expenses. Because non-county nursing home unreimbursed expenses under the medicare upper limit are used to claim additional IGT funds, county unreimbursed expenses are not the only factor responsible for generating IGT funds.

7. In 1995-97, the IGT payment of $37.1 million to county nursing homes exceeded the standard federal match of 59% for county nursing home unreimbursed expenses. However, in 1997-99, based on estimated unreimbursed losses of $63.6 million in 1997-98 and $68.0 million in 1998-99, the county would receive $37.5 million in 1997-98 and $40.1 million with a 59% match compared to $37.1 million under current law.

8. In addition to unreimbursed expenses, counties receive payments through the MA nursing home formula for reimbursed expenses. Table 2 compares the reimbursement rates under MA between governmental (county), nonprofit and proprietary nursing homes, which were reported in the 1995 survey of nursing homes. The figures in the survey do not include the effect of the special county nursing home supplements, but Table 2 includes an estimated amount for these payments.

TABLE 2

Average Per Diem Rates By Level of Care
December 31, 1995

	Proprietary	Nonprofit	Governmental Unadjusted	Governmental Adjusted
Skilled Care	$82.71	$86.84	$90.38	$104.24
Intermediate Care (ICF 1)	69.36	71.82	78.72	92.58
Developmentally Disabled	108.27	127.86	119.12	132.98

Note: The adjusted governmental rate includes the estimated effect of the $37.1 million in special county nursing home payments.

9. The following arguments could be made for providing a larger share of IGT funds to county nursing homes:

- IGT funds are based on county nursing home expenses.

- Current supplemental payments to county nursing homes are less than the total of their reimbursed expenses, and beginning in 1997-98, the current $37.1 million will be less than 59% of the counties' unreimbursed expenses.

- County homes' higher costs are due, in large part, to higher labor costs. Federal reimbursement for these costs allow counties to meet labor costs and allow higher wages and fringe benefits to be paid to county nursing home employes.

- To the extent that federal dollars reduce county expenditures on nursing homes, county tax levies can be reduced.

10. Alternatively, it could be argued that:

- The portion of the IGT funds not provided to the county nursing homes could not be claimed without the gap in the medicare upper limit due to non-county unreimbursed expenses.

- Based on 1995 data and including the effect of the county special payments, county nursing homes were reimbursed at a rate that, in general, was higher for a resident classified at the same level of care as in non-county facilities.

- The operating deficit reduction program encourages inefficiency, because costs in excess of the MA formula are recouped by counties.

11. The Committee could provide counties some additional supplemental payments so that the payments would be equal to the product of the federal sharing percentage for MA (approximately 59% currently) and the total amount of county certified losses. This would provide an estimated $37.5 million in 1997-98 and $40.1 million in 1998-99. Basing the supplemental payment on a percentage of county losses would maintain an incentive for counties to certify losses for IGT claims, and could allow elimination of the current provision that provides that IGT claims above budgeted amounts would be reserved for county payments.

ALTERNATIVES TO BILL

1. Maintain current law by: (a) maintaining the amount of funding for special supplemental payments to counties at the current level of $37.1 million; and (b) specifying that any additional federal MA funds that were not anticipated prior to the enactment of the biennial budget act or other legislation would be paid to county-owned nursing homes in addition to the $37.1 million, subject to the limit that the total of all special payments could not exceed the size of the home's deficit.

2. Modify the Governor's recommendation by providing total supplemental payments to counties equal to the product of the federal sharing percentage for MA (59% currently) and the total amount of county certified losses. This would provide an estimated $37.5 million in 1997-98 and $40.1 million in 1998-99 in supplemental payments to counties and increase MA benefits costs by $400,000 GPR in 1997-98 and $3,000,000 GPR in 1998-99. Specify that individual supplemental payments to counties would be allocated based on the current formula. In addition, repeal the current provision that all IGT claims above budgeted amounts would be used for county supplemental payments.

Alternative 2	GPR
1997-99 FUNDING (Change to Bill)	$3,400,000

Prepared by: Richard Megna

MO# Alt 1

BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

AYE 14 NO 2 ABS 0

Representative Ourada

HEALTH AND FAMILY SERVICES

Consultant to Determine Medicare Upper Limit for Nursing Homes

Motion:

Move to require the Department of Administration to hire a consultant to determine and recommend to the Department of Health and Family Services the amount that should be used for the medicare upper limit for nursing home payments under the medical assistance program, beginning for the 1997-98 fiscal year. Specify that DHFS would not be required to accept the recommendations of the consultant.

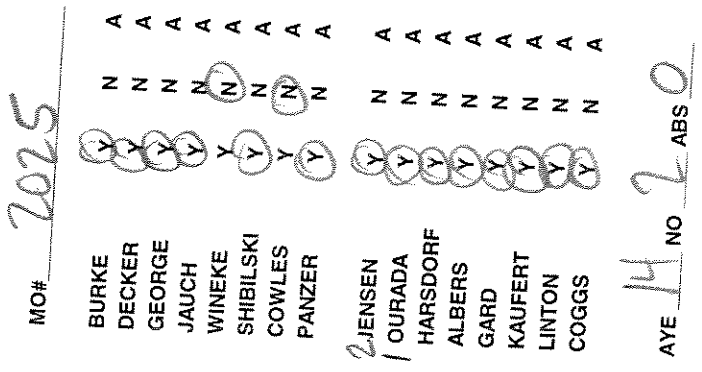
Note:

Under federal regulations, the state's aggregate payments for inpatient nursing home services under medical assistance may not exceed the amount that the state estimates would have been paid under medicare payment principles in effect at the time the services were provided. This payment limitation is referred to as the "medicare upper limit."

The medicare upper limit has been a factor in the amount of federal MA matching funds that DHFS has claimed based on unreimbursed expenses of county-owned nursing homes under the intergovernmental transfer program (IGT). These federal matching funds are often referred to as "IGT claims." In 1995-96, Wisconsin did not fully utilized the unreimbursed expenses of county-owned nursing homes due to concerns of exceeding the medicare upper limit.

This motion would require the Department of Administration to hire a consultant to estimate the medicare upper limit for nursing home payments under medical assistance. DHFS would not be required to adopt the amount recommended by the consultant. The motion would not provide any funding to DOA to hire the consultant. Consequently, DOA would be required to internally reallocate funding to support the costs of the consultant.

Motion #2025



To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Reestimate of GPR Revenue from MA Reimbursement for the State Centers (DHFS -- Medical Assistance)

CURRENT LAW

Most of the costs of operating the State Centers for the Developmentally Disabled ("Centers") are supported under the medical assistance (MA) program. The Centers' operating costs are budgeted as program revenue to reflect the transfer of funds from the MA program to the Division of Care and Treatment Facilities. However, certain indirect costs relating to the operation of the Centers, although reimbursable under MA, are budgeted with GPR funds, rather than MA funds. These costs include depreciation, interest expenses and certain administrative overhead costs. MA payment for these costs are deposited to the general fund and credited as GPR-earned. Typically, the actual amount of these GPR-funded costs are not determined until the year following the year in which these costs were incurred, when DHFS reconciles final actual costs with billed MA costs.

In 1995-96, MA reimbursements totalling $6,799,200 were credited to the general fund as GPR-earned. This amount was based on estimated depreciation, interest and administrative overhead costs at the Centers for that fiscal year.

GOVERNOR

Estimate total MA reimbursements for deposit to the general fund of $6,803,500, $6,800,000 and $6,940,000 for fiscal years 1996-97, 1997-98 and 1998-99, respectively.

DISCUSSION POINTS

1. DHFS has nearly completed reconciling 1995-96 actual costs for the Centers with MA reimbursement for those costs. The MA-reimbursable amounts expended for depreciation, interest and administrative overhead for 1995-96 is estimated to be $8,376,400. This is expected to increase revenue deposited to the general fund by $1,577,200 in 1996-97.

2. It is currently estimated that MA reimbursements for costs relating to the Centers will total $8,127,000 in 1996-97 and 1997-98. These amounts represent an increase of $1,327,000 in 1997-98 and $1,187,000 in 1998-99, from the amounts assumed in SB 77.

MODIFICATION TO BILL

Increase estimated GPR-earned revenues by $1,327,000 in 1997-98 and $1,187,000 in 1998-99 to reflect reestimates of MA reimbursement to the general fund. In addition, increase projected revenues to the general fund in 1996-97 by $1,577,200.

Modification	GPR
1997-99 REVENUE (Change to Bill)	$2,514,000

Prepared by: Richard Megna

MO# modification

BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

AYE 16 NO 0 ABS 0

To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

County Support for Certain Residents at the State Centers (DHFS -- Medical Assistance)

[LFB Summary: Page 263, #8 (part)]

CURRENT LAW

Counties are required to pay 10% of the cost of care for residents at the State Centers for the Developmentally Disabled ("Centers") who are determined by an independent, professional review to be appropriate for community care. Current law does not specify how the Department of Health and Family Services (DHFS) is to determine who is appropriate for community care. However, DHFS rules define this to mean clients whose care needs can be met by noninstitutional services and for whom there is "adequate state and federal funding to support community services." DHFS policy requires counties to contribute to the costs of care for individuals whose care can be provided at costs below the average amount provided to counties for the costs of care of individuals participating in the community integration program (CIP IA).

GOVERNOR

Authorize DHFS to bill counties $184 per day for services provided on or after December 31, 1997, to any resident, including persons who have been admitted for more than 180 consecutive days, if an independent professional review determines that the resident can be supported in the community at a cost of $184 per day or less.

Increase estimates of revenue deposited to the state's general fund by $458,500 in 1997-98 and $479,000 in 1998-99 to reflect projected county contributions for the costs of care of residents at the Centers.

DISCUSSION POINTS

1. Even though DHFS has been authorized to bill counties for services provided at the Centers to individuals who are determined to be appropriate for community care since 1982, DHFS first began administering this provision in the current fiscal year, following the promulgation of rules in April, 1996, relating to county appeals of these independent professional reviews. To date, DHFS has not recovered any of its costs from counties.

2. Every six months, each Center resident is reassessed to determine whether his or her care needs can best be addressed at the Center or in a community-based setting. Based on initial determinations made by a physician and social worker with whom DHFS contracts, staff at the Centers estimate the costs of services that would be required to meet an individual's care needs in the community. If these costs are less than the current average CIP IA rate (currently $153 per day), DHFS notifies the resident's home county of its intent to begin billing the county for services, beginning 180 days following county notification.

The county is provided the option of appealing the determination within 60 days following notification. Any appeal is reviewed by a team consisting of representatives of the Division of Care and Treatment Facilities, the Division of Supportive Living and county agencies. This team makes a recommendation on the validity of the appeal to the Administrator of the Division of Supportive Living, who must rule on the appeal within 45 days after receiving a written appeal.

3. Counties may appeal a determination based on guardian opposition to a placement outside of the Center. In such instances, charges to the county are typically postponed until after the next Watts review hearing (an annual hearing before a court to determine the appropriateness of a placement). If, at the hearing, the court orders the person to remain at the Center, the appeal is granted. However, if the court orders the person to return to the community, the 180-day period begins on the date of the court's notice to the county agency. In addition, DHFS may delay the effective date of the 10% charge back for up to 60 days for a person whose plan for community services has been approved by DHFS and is awaiting implementation.

4. DHFS intends to begin billing counties for care provided to eleven residents at Northern Center, for services provided on and after May 26, 1997. In June, DHFS expects a similar number of county billings for services provided to clients at Southern Center. Similarly, several individuals at Central Center will likely be identified under the review process, although residents at Central Center are more medically fragile and have greater care needs than residents at the other Centers.

Because these clients have been determined to be the most appropriate for community placement and the implementation of the assessment will create a greater incentive for counties to place residents under CIP IA, it may be reasonable to assume that, under current law, counties will be assessed for the care of an average of approximately 15 residents annually. Based on the current MA reimbursement rates for the Centers (approximately $300 per day per resident), the estimated revenue that would be collected from counties under current law would be approximately $164,300 annually (15 residents x $30 per day x 365 days per year.)

6. Under SB 77, DHFS would be authorized to assess counties $184 per day for services provided to these clients on and after January 1, 1998. This will likely increase: (a) the number of county appeals; and (b) the number of placements made by counties in order to avoid the daily assessment. It is estimated that this would reduce the number of individuals subject to the assessment by approximately 50%. The projected revenue that would be collected under this proposal would be $334,000 in 1997-98 and $503,700 in 1998-99. This represents a decrease of $124,500 in 1997-98 and an increase of $24,700 in 1998-99 from the amounts budgeted in the bill.

7. As an alternative to increasing the assessment to $184 per day, effective January 1, 1998, the bill could be amended to increase the assessment to either: (a) $124 per day, which would represent the state's share of the costs of caring for residents at the Centers ($300 x .41); or (b) $48 per day, which would represent the state's share (41%) of the cost difference between the Center's rate and the proposed CIP IA rate [($300 - $184) x .41].

ALTERNATIVES TO BILL

1. Adopt the Governor's recommendation to increase the county assessment to $184 per day, effective for services provided on and after January 1, 1998. Reduce revenue deposited to the general fund by $124,500 in 1997-98 and increase revenue deposited to the general fund by $24,700 in 1998-99 to reflect reestimates of the Governor's proposal.

Alternative 1	GPR
1997-99 REVENUE (Change to Bill)	- $99,800

2. Modify the Governor's recommendation by increasing the county assessment to $124 per day, effective for services provided on and after January 1, 1998. Reduce revenue deposited to the general fund by $150,800 in 1997-98 and $134,700 in 1998-99 to reflect the projected revenue that would be collected under this alternative.

Alternative 2	GPR
1997-99 REVENUE (Change to Bill)	- $285,500

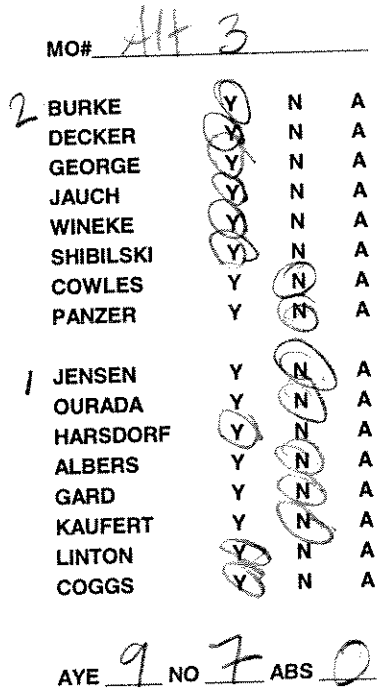
3. Modify the Governor's recommendation by increasing the county assessment to $48 per day, effective for services provided on and after January 1, 1998. Reduce revenue deposited to the general fund by $245,000 in 1997-98 and $216,200 in 1998-99 to reflect the projected revenue that would be collected under this alternative.

Alternative 3	GPR
1997-99 REVENUE (Change to Bill)	- $461,200

4. Maintain current law. Reduce revenue deposited to the general fund by $294,200 in 1997-98 and $314.700 in 1998-99 to reflect estimates of revenue that will be collected under the current 10% assessment ($164,300 annually).

Alternative 4	GPR
1997-99 REVENUE (Change to Bill)	- $608,900

Prepared by: Charles Morgan



Senator Wineke

HEALTH AND FAMILY SERVICES

County Support for Certain Residents at the State Centers

Motion:

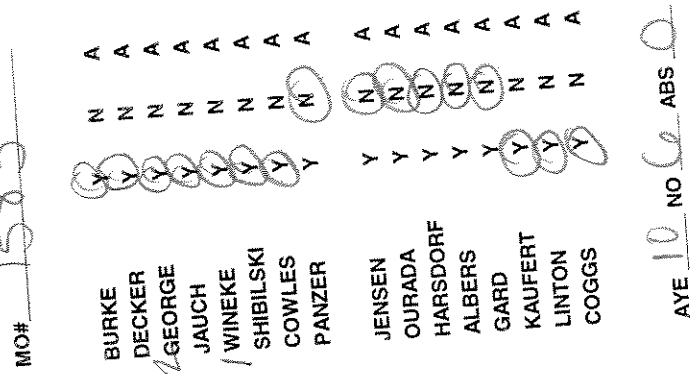
Move to prohibit DHFS from assessing a county for the costs of caring for any person at the Centers who is determined to be appropriate for community placement if the resident's guardian objects to the resident's placement in the community.

Note:

Currently, counties are required to pay 10% of the cost of care for individuals who are judged to be appropriate for community placement. By rule, a county may appeal an assessment based on guardian opposition to a placement in the community. In such cases, charges to the county are typically postponed until after the next Watts review hearing. If, at the hearing, the court orders the person to remain at the Center, the appeal is granted. However, if the court orders the person to return to the community, DHFS begins billing the county after a 180-day notification period.

SB 77 would authorize DHFS to bill counties $184 per day for services provided on or after December 31, 1997, to residents, including persons who have been admitted for more than 180 consecutive days, if an independent professional review determines that the resident can be supported in the community at a cost of $184 per day or less.

This motion would prohibit DHFS from assessing these charges in cases where the guardian objects to placement in the community.



Motion #1583

To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Emergency Medical Services (EMS) Rates (DHFS -- Medical Assistance)

[LFB Summary: Page 258, #4]

CURRENT LAW

The state's medical assistance (MA) program covers certain emergency and non-emergency ambulance transportation services in cases where a recipient is suffering from an illness or injury that contraindicates transportation by other means.

Ambulance providers are paid the sum of a basic life support (BLS) rate and a per mile rate under a maximum fee schedule which recognizes cost differences between providers that operate in Milwaukee County, metropolitan areas and other areas of the state. Table 1 summarizes the current MA ambulance transportation rate structure.

TABLE 1

Current MA Rates Paid for EMS Transportation Services

	Statewide	Metropolitan	Milwaukee
BLS Rate	$76.51	$81.91	$109.29
Per Mile Rate	1.92	2.46	3.48

GOVERNOR

Establish an advanced life support (ALS) reimbursement rate for ambulance providers, beginning in 1998-99. Provide $608,400 ($251,800 GPR and $356,600 FED) in 1998-99 to support the projected costs of establishing this higher ALS rate. Table 2 summarizes the ALS rate structure recommended by the Governor.

TABLE 2

MA Rates Paid for EMS Transportation Services
SB 77

	Statewide	Metropolitan	Milwaukee
BLS Rate*	$76.51	$81.91	$109.29
ALS Rate (188% of BLS Rate)	143.84	153.99	205.47
Per Mile Rate	1.92	2.46	3.48

*Excludes Governor's recommended rate increase for non-institutional providers (1% in each year).

DISCUSSION POINTS

1. Basic life support (BLS) services are generally defined as emergency medical care rendered to an individual by a basic emergency medical technician (EMT). Authorized activities of a basic EMT include transportation of patients, administering devices to assist the patients' breathing, and defibrillation.

2. Advanced life support (ALS) services are generally defined as emergency medical care provided by an intermediate or advanced EMT. Authorized activities of an intermediate or advanced EMT include those of a basic EMT as well as administration of intravenous infusions, drawing of blood samples, and gastric and endotracheal intubation.

3. Of the 450 ambulance providers in the state, 115 providers (26%) are certified to provide ALS services. Approximately 70% of ALS certified providers are operated by municipalities.

4. Medicare and MA programs in other states have an EMS rate structure that differentiates between ALS and BLS services. Under medicare, the ALS rate is approximately 188% of the BLS rate. The Governor's recommended ALS rate is 188% of the current BLS rate.

5. Wisconsin's MA program pays medicare premiums, coinsurance and deductibles for individuals who are eligible for both MA and medicare. Because approximately 20% of all ambulance trips billed to MA on behalf of these MA/medicare dual eligibles are ALS trips, the funding budgeted in SB 77 assumes that 20% of all ambulance trips for the total MA population will be ALS trips. However, the 20% utilization rate reflects the experience of an elderly population, who may use ambulance services for non-emergency transportation more frequently than the general MA population. For example, when authorized by a physician, an ambulance may be used to transport an elderly individual from a hospital to a nursing home.

6. Information collected from Iowa, Michigan and Minnesota indicate that, in these states that have both BLS and ALS rates, at least 50% of MA ambulance trips are billed under the higher ALS rate. Based on a projected 50% utilization rate for ALS services, the estimated cost of establishing an ALS rate in Wisconsin equal to 188% of the BLS rate would be $1,631,100 ($674,900 GPR and $956,200) in 1998-99. This reestimate is $1,022,700 ($423,100 GPR and $599,600 FED) more than the amount budgeted for this item in SB 77.

This reestimate also reflects an expected decrease in ambulance utilization as a result of the AFDC/healthy start managed care expansion. Health maintenance organizations (HMOs) are responsible for reimbursing ambulance providers that serve MA recipients who are enrolled in HMOs. Therefore, the total fee-for-service cost for ambulance transportation is expected to decrease in the 1997-99 biennium.

7. The primary argument for establishing an ALS rate is to reflect the additional training and equipment necessary to provide ALS services. However, the current BLS rate structure already reflects, to some extent, the additional costs incurred by ALS ambulance operators. For example, the BLS base rate for services provided in Milwaukee County is approximately $33.00 higher than the statewide rate to account for the fact that the proportion of ALS ambulances in Milwaukee is greater than in the rest of the state. This factor could be an argument for retaining the current rate structure.

8. As an alternative to the Governor's recommendation, the Committee could establish the ALS rate at 120% of the current BLS rate, beginning in 1998-99. The estimated cost of establishing an ALS rate at this level would be $1,041,100 ($430,800 GPR and $610,300 FED). This is $432,700 ($179,000 GPR and $253,700 FED) more than the amount that is provided in the bill for this item, but $244,100 GPR and $345,900 less than the amount required to support the Governor's proposal, as reestimated. Table 3 summarizes a proposed ALS rate structure that is 120% of the current BLS rate.

TABLE 3

Alternative EMS Rate Structure

	Statewide	Metropolitan	Milwaukee
BLS Rate	$76.51	$81.91	$109.29
ALS Rate (120% of BLS Rate)	91.82	98.29	131.15
Per Mile Rate	1.92	2.46	3.48

ALTERNATIVES TO BILL

1. Approve the Governor's recommendation. In addition, increase MA benefits funding by $1,022,700 ($423,100 GPR and $599,600 FED) in 1998-99 to reflect a reestimate of the costs of establishing an ALS rate at 188% of the BLS rate.

Alternative 1	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	$423,100	$599,600	$1,022,700

2. Modify the Governor's recommendation by establishing an ALS rate at 120% of the BLS rate. In addition, increase MA benefits funding by $432,700 ($179,000 GPR and $253,700 FED) in 1998-99 to reflect the costs of establishing this rate.

Alternative 2	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	$179,000	$253,700	$432,700

3. Maintain current law.

Alternative 3	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	- $251,800	- $356,600	- $608,400

Prepared by: Amie T. Goldman

MO# 41K 2

BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

12

AYE 12 NO 4 ABS 0

To: Joint Committee on Finance

From: Bob Lang, Director
Legislative Fiscal Bureau

ISSUE

Dental Sealants (DHFS -- Medical Assistance)

[LFB Summary: Page 265, #11]

CURRENT LAW

Currently, the state's medical assistance (MA) program provides coverage of dental sealants only in cases where children are referred for the service as a result of an early and periodic screening, diagnostic and testing (EPSDT) screen. Dental sealants are not covered unless this referral is made.

GOVERNOR

Provide $1,500,700 ($617,100 GPR and $883,600 FED) in 1997-98 and $16,700 ($6,800 GPR and $9,900 FED) in 1998-99 to establish dental sealants as a covered service for children under medical assistance.

DISCUSSION POINTS

Dental Sealants

1. Dental sealants are a plastic material applied to the chewing surface of molars. The plastic sealant bonds into the depressions and grooves (pits and fissures) of the chewing surfaces of the back teeth. The sealant acts as a barrier, protecting enamel from plaque and acids and, thereby, prevents the development of tooth decay on those surfaces.

2. Dental sealants are accepted by the dental community as an effective preventive service. Research has shown that dental sealants, which are applied correctly and are properly maintained, in combination with the effective use of fluoride, can completely prevent cavities in many children. One study found that approximately 70% of teeth which were not sealed would develop a cavity over a ten-year period, compared to approximately 22% of sealed teeth.

3. Thirty-eight of 39 states surveyed by DHFS reported coverage of dental sealants as an MA benefit. Attachment 1 summarizes the findings of this survey.

4. Preventive care can be less expensive than symptomatic treatment. A number of cost-benefit studies have attempted to quantify the monetary benefits of sealing children's teeth. These studies have found that the cost of sealing children's teeth are less than the future cost of filling cavities that may occur in unsealed teeth.

5. However, the cost of a prevention activity, such as the application of sealants, occurs when the service is delivered, while the benefits accrue over time. This time consideration is particularly relevant when budgeting for the MA program. While the costs of providing dental sealants would be incurred in the 1997-99 biennium, the benefits associated with this prevention activity will primarily occur in subsequent biennia. Further, because the MA-eligible population is not static, the cost savings of providing dental sealants is not fully realized by the MA program.

6. Current estimates of the net cost of providing dental sealants as a covered MA benefit are $594,900 ($244,600 GPR and $350,300 FED) in 1997-98 and $196,600 ($81,300 GPR and $115,300 FED). This estimate is $905,800 ($372,500 GPR and $533,300 FED) less in 1997-98 and $179,900 ($74,500 GPR and $105,400 FED) more in 1998-99 than the administration's estimate.

The current estimate of the net cost of providing dental sealants as a covered MA benefit reflects that: (a) many children who are eligible for this service are enrolled in HMOs and the bill assumes a fee-for-service cost for providing dental sealants to these children; and (b) the majority of the savings resulting from the addition of this preventive service will be realized beyond the 1997-99 biennium, while the bill assumes too much cost savings in 1997-99.

7. The state is obligated under contract to adjust the HMO capitation rate when a new MA service or benefit is added during the contract period. Under the Governor's recommendation, it is assumed that the coverage of dental sealants as an MA benefit would be effective on July 1, 1997. At that time, there will be six months remaining under the current HMO contract. However, the Governor's estimate does not account for a capitation adjustment for the HMOs if this benefit is added during the current contract period.

Since DHFS requires time to formally notify recipients and providers about a new service, the Committee could establish January 1, 1998, as the effective date for the coverage of dental

sealants. In addition, if the benefit were effective January 1, 1998, the current HMO contract would not require an amendment. However, the addition of dental sealants as a covered MA benefit will be one of the many factors taken into consideration during the negotiation of the next HMO contract.

If the Committee establishes January 1, 1998, as the effective date of the service there will be a decrease in costs in 1997-98 and an increase in costs in 1998-99 from the bill. The cost increase in 1998-99 is due to the fact that there will be fewer sealants applied in 1997-98 and, therefore, reduced savings resulting from avoided cavities in 1998-99.

Access to Dental Services

8. Dental sealants may be an effective prevention service, but unless a child has access to a dentist and receives routine dental care, the addition of dental sealants as an MA benefit will be of limited value. Many dentists in Wisconsin are unwilling to accept MA patients for a variety of reasons, including: (a) low reimbursement rates; (b) high rates of missed appointments; and (c) prior authorization requirements for services that dentists consider medically necessary, such as braces and root canals.

9. HMOs that contract with the state for health services cover dental services for state employes as part of the state's uniform benefits package. However, the provision of dental services is optional for HMOs that contract with the state for providing services to MA recipients. Currently, there are HMOs that contract with the state for the provision of services to both MA recipients and state employes.

10. Currently, eight HMOs provide dental services to MA enrollees in certain counties. As of March, 1997, approximately 70% of all MA HMO enrollees were enrolled in an HMO that provided dental services. Attachment 2 provides a listing of the HMOs that have elected to provide dental services to MA enrollees.

If an HMO elects to provide dental services to MA recipients, the HMO is paid an additional dental capitation rate per enrollee. Under the current HMO contract, which expires December 31, 1997, the average dental capitation rate for children in the expansion regions is $5.77 per child per month.

SB 77 assumes that nearly all AFDC- and healthy start-related MA eligibles will be enrolled in HMOs by June 30, 1997, and that all HMOs will elect to cover dental services. Therefore, the dental capitation rate for nearly all AFDC- and healthy start-related eligibles is included in the base estimate of MA costs.

11. Some states require HMOs that provide services to MA recipients to include dental services as part of a comprehensive health package. Minnesota also requires HMOs that provide services to public employes to provide the same services to MA recipients. In order to improve

dental access for MA eligible children, the Committee could direct DHFS to require HMOs to cover dental services, beginning January 1, 1998. In addition, the Committee could direct DHFS to establish target dental utilization rates as part of the next HMO contract. For example, DHFS could require that HMOs improve dental access by 10% in calendar year 1998 and another 10% in 1999. This would be consistent with current DHFS policy to require by contract utilization targets for early and periodic screening, diagnostic and testing (HealthCheck) screens.

12. Other states, including Illinois and Minnesota, have utilized dental managed care as a means for improving access to dental services. In these states, dental services are excluded from the benefit package covered by HMOs and instead are contracted for with a single provider for the state's entire MA population.

Illinois currently contracts with a dental managed care organization to provide dental services to all MA recipients. The contract between this organization and the state establishes a utilization target. The managed care organization must provide dental services to 50% of the eligible population per year, or face financial penalties. The current dental capitation rate paid per child per month in Illinois under this contract is less than the current MA dental capitation rate in Wisconsin. Dentists are reimbursed by the managed care organization on a fee-for-service basis.

Minnesota plans to utilize dental managed care to provide dental benefits for all public employes and MA recipients enrolled in HMOs as of January 1, 1998. The state recently conducted a request for proposal (RFP) and three dental managed care organizations submitted a bid.

As a means of improving access to dental services for the states' MA population, the Committee could direct DHFS to exclude dental services from the basic HMO contract and, instead, contract for the provision of dental services for MA HMO enrollees with a single dental managed care organization, beginning January 1, 1998.

ALTERNATIVES TO BILL

A. Governor's Recommendation

1. Reduce MA benefits funding by $905,800 ($372,500 GPR and $533,300 FED) in 1997-98 and increase MA benefits funding by $179,900 ($74,500 GPR and $105,400 FED) in 1998-99 to reflect reestimates of the costs and savings of establishing dental sealants as an MA covered benefit on the bill's general effective date.

Alternative A1	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	- $298,000	- $427,900	- $725,900

2. Modify the Governor's recommendation by establishing a January 1, 1998, effective date for the coverage of dental sealants under the MA program. Reduce MA benefits funding by $452,900 ($186,200 GPR and $266,700 FED) in 1997-98 and increase MA benefits funding by $331,600 ($137,200 GPR and $194,400) in 1998-99.

Alternative A2	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	- $49,800	- $72,300	- $121,300

3. Maintain current law.

Alternative A3	GPR	FED	TOTAL
1997-99 FUNDING (Change to Bill)	- $623,900	- $893,500	- $1,517,400

B. HMO Coverage of Dental Services

1. Direct DHFS to require HMOs to provide dental services for all MA HMO enrollees, effective January 1, 1998. In addition, require DHFS to require by contract target dental utilization rates.

2. Direct DHFS to exclude dental services from the benefit package provided by HMOs. Instead, direct DHFS to contract with a dental managed care organization for the provision of dental services for all MA HMO enrollees, beginning January 1, 1998.

3. Maintain current law.

Prepared by: Ami

MO# A2

BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

AYE 16 NO 0 ABS 0

MO# B1

BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
LINTON	Y	N	A
COGGS	Y	N	A

AYE 2 NO 14 ABS 0

paper #430

MO# B2

1	BURKE	Y	N	A
	DECKER	Y	N	A
	GEORGE	Y	N	A
	JAUCH	Y	N	A
	WINEKE	Y	N	A
	SHIBILSKI	Y	N	A
	COWLES	Y	N	A
	PANZER	Y	N	A
	JENSEN	Y	N	A
	OURADA	Y	N	A
	HARSDORF	Y	N	A
	ALBERS	Y	N	A
	GARD	Y	N	A
	KAUFERT	Y	N	A
	LINTON	Y	N	A
2	COGGS	Y	N	A

AYE 6 NO 10 ABS ____

Senator Jauch

HEALTH AND FAMILY SERVICES

MA Dental Services Pilot Program

Motion:

Move to direct DHFS, in consultation with the major dental association in Wisconsin, to develop a pilot program, effective through June 30, 1999, for the provision of medical assistance (MA) dental services in Ashland, Douglas, Bayfield and Iron Counties. Direct DHFS to determine an estimate of the costs of providing MA dental benefits to MA recipients in this area in the absence of such a program, and provide this funding to an entity that would be responsible for providing dental services to all MA recipients in the four-county region.

Specify that: (a) each enrollee would identify their dental provider, and, if no dental provider is identified, a dental provider would be assigned to the recipient; (b) enrollees would be entitled to all dental services currently covered under the MA program.

Direct DHFS to seek any federal waivers necessary to implement this program. Specify that if, after receiving any necessary waivers, DHFS determines that the costs of the pilot program would not exceed the costs of providing MA dental services in these counties in the absence of the pilot program and that the pilot program would increase access to MA dental services for MA recipients, the Department would implement the program by January 1, 1998.

Note:

Under this pilot program, DHFS would contract with a program administrator that would: (a) accept a capitation payment from DHFS for each enrolled MA recipient; (b) enroll participating dentists; and (c) be required to coordinate activities such as outreach and patient education with county health departments. In addition, the program administrator would be responsible for paying participating dentists for all MA covered dental services provided to MA recipients in these four counties. Participating dental providers would be paid by the program administrator on a fee-for-service basis.

MA enrollees in Ashland, Douglas, Bayfield and Iron counties would be required to select a primary dental provider from among those participating in the pilot program and would receive all of their dental services from these participating dentists.

The pilot program would be evaluated based on its ability to: (a) improve access to dental services for MA recipients in these four counties; and (b) reduce the number of emergency room visits for dental services.

Motion #1034

MO# 1034

BURKE	Y	N	A
DECKER	Y	N	A
GEORGE	Y	N	A
JAUCH	Y	N	A
WINEKE	Y	N	A
SHIBILSKI	Y	N	A
COWLES	Y	N	A
PANZER	Y	N	A
JENSEN	Y	N	A
OURADA	Y	N	A
HARSDORF	Y	N	A
ALBERS	Y	N	A
GARD	Y	N	A
KAUFERT	Y	N	A
2 LINTON	Y	N	A
COGGS	Y	N	A

AYE 16 NO 0 ABS 0

ATTACHMENT 1

Sealants As A Covered Service Under Medicaid

Alaska	Covered per tooth for children age 21 and under one annually.
Arizona	Covered for all non-carious permanent first molars.
Arkansas	Covered for first and second permanent molars only.
California	Covered for permanent first molars on beneficiaries age 8 and under; on permanent second molars up to age 14.
Colorado	Long list attached to survey (too length to list).
Delaware	100% coverage on sealants.
Florida	Covered for bicuspid initial placement and first and second permanent molars.
Georgia	Covered for first and second permanent molars (must be non-carious).
Hawaii	Covered for occlusal surfaces of permanent molars age 6-15.
Idaho	Covered for children ages 6-16; permanent molars, primary molars with prior approval only.
Illinois	Permanent molars ages 5-17.
Indiana	Covered for permanent and deciduous molars.
Iowa	Covered for only one application per tooth per lifetime ages 5-15.
Louisiana	Covered for first permanent molar through age 9, second permanent molar through age 15.
Maryland	Covered for occlusal surfaces of permanent teeth but not over restorations.
Massachusetts	Covered for age 21 and under.
Michigan	Covered for ages 5-15 on fully erupted first and second molars.
Missouri	Covered for silicate restoration including local anesthesia and treatment base.
Nebraska	Covered for molars and premolars within three years of eruption.
New Jersey	Covered for a one-time application limited to recipients age 16 and under.
New Mexico	Covered and limited to one application per permanent posterior tooth for recipients age 21 and under.
New York	Covered and restricted to previously unrestored permanent first and second molars with no signs of occlusal or proximal caries for patients ages 5-15.
North Carolina	Covered for primary and nearly erupted permanent premolars and first and second molars for ages 21 and under. Allow one in a lifetime replacement of sealants.
Ohio	Covered on permanent first and second molars for recipients age 18 and under.
Oklahoma	Covered for tooth numbers listed for caries-free virgin teeth for ages 8 and under, ages 13 and under and through age 14.
South Carolina	Covered on newly erupted molars, eight per lifetime.
South Dakota	Covered for first and second molars for age 20 and under with a 3-year time limitation.
Texas	Covered only on pits and fissures of permanent molars of children ages 14 and under, must be free of proximal caries and restorations.
Utah	Covered on premolars and molars for ages 0-18.
Vermont	Covered for first and second permanent molars for ages 5-21.
Washington	Covered for primary and permanent teeth for age 18 and under.
West Virginia	Covered for posterior permanent teeth only for children.
Wisconsin	Covered for children who have had an EPSDT screen during the previous year.
Wyoming	Covered for permanent molars with occlusal surfaces without caries and/or restorations.

ATTACHMENT 2

HMO Coverage of Dental Services for MA Enrollees as of March, 1997

County/HMO	Provides Dental
Brown	
Compcare	Yes
Network Health Plan	Yes
United Health	No
Calumet	
Network Health Plan	Yes
United Health	No
Fond du Lac	
Dean Care	No
Genesis	No
Network Health Plan	Yes
United Health	No
Unity	No
Green Lake	
Dean Care	No
Network Health Plan	Yes
United Health	No
Jefferson	
Dean Care	No
Genesis	Yes
Mercy Care	No
Physicians Plus	No
Kenosha	
Compcare	Yes
Genesis	Yes
Humana	Yes
Managed Health Services	Yes
Maxicare	Yes
Network Health Plan	Yes
Primecare	Yes
Manitowoc	
Compcare	Yes
Genesis	No
Network Health Plan	Yes
Milwaukee	
Compcare	Yes
Family Health Plan	Yes
Genesis	Yes
Humana	Yes
Managed Health Services	Yes
Maxicare	Yes
Network Health Plan	Yes
Primecare	Yes
Outagamie	
Network Health Plan	Yes
United Health	No

County/HMO	Provides Dental
Ozaukee	
Compcare	Yes
Genesis	Yes
Managed Health Services	Yes
Maxicare	Yes
Network Health Plan	Yes
Primecare	Yes
Racine	
Compcare	Yes
Genesis	Yes
Humana	Yes
Managed Health Services	Yes
Maxicare	Yes
Network Health Plan	Yes
Primecare	Yes
Sheboygan	
Compcare	Yes
Genesis	Yes
Network Health Plan	Yes
Walworth	
Compcare	Yes
Dean Care	No
Mercy Care Health Plan	No
Washington	
Compcare	Yes
Dean Care	No
Genesis	Yes
Managed Health Services	Yes
Maxicare	Yes
Network Health Plan	Yes
Primecare	Yes
Waukesha	
Compcare	Yes
Family Health Plan	Yes
Humana	Yes
Managed Health Services	Yes
Maxicare	Yes
Network Health Plan	Yes
Primecare	Yes
Waupaca	
Network Health Plan	Yes
Security Health Plan	No
United Health	No
Waushara	
Network Health Plan	Yes
United Health	No